*Orthopedic History*

Instructions: Answer each of the following questions. Fully explain all questions that were answered YES in the space below.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sport:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

HAVE YOU EVER HAD OR ARE YOU CURRENTLY EXPERIENCING AN INJURY TO:

|  |  |  |  |
| --- | --- | --- | --- |
|  | No | Yes | If yes, please explain |
| Head/Face |  |  |  |
| Neck |  |  |  |
| Burner/Stinger |  |  |  |
| Shoulder |  |  |  |
| Elbow/Arm |  |  |  |
| Wrist |  |  |  |
| Hand |  |  |  |
| Fingers |  |  |  |
| Spine/Low Back |  |  |  |
| Rib Fracture |  |  |  |
| Hip |  |  |  |
| Hamstring |  |  |  |
| Groin |  |  |  |
| Quad |  |  |  |
| Knee |  |  |  |
| Ankle/Lower Leg |  |  |  |
| Achilles Tendon |  |  |  |
| Foot/Toes |  |  |  |

Has any body part EVER been injected for practice or play? \_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_No

If yes, list the body part and date of injection: \_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list ALL inpatient and outpatient surgeries including arthroscopic procedures that you have had. List the date, nature of the operation and the doctor’s name that performed the operation.

Date: Operation: Doctor:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Health History*

Instructions: Answer each of the following questions. Fully explain all questions that were answered YES in the space below. List the question number, dates, procedures, hospitalization and Doctors’ names where appropriate.

HAVE YOU EVER HAD OR ARE YOU CURRENTLY EXPERIENCING:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **No** | **Yes** |  |  | **No** | **Yes** |
| 1. | Rheumatic Fever? |  |  | 21. | Liver or gall bladder infections? |  |  |
| 2. | Malaria? |  |  | 22. | Kidney or bladder infections? |  |  |
| 3. | Hepatitis (Jaundice)? |  |  | 23. | Frequent urination? |  |  |
| 4. | Meningitis? |  |  | 24. | Difficulty or pain urinating? |  |  |
| 5. | Tuberculosis? |  |  | 25. | Passed blood, puss, or sugar in urine? |  |  |
| 6. | Mononucleosis? |  |  | 26. | Painful menstruation? |  |  |
| 7. | Herpes Simplex or Shingles? |  |  | 27. | Breast mass or tenderness? |  |  |
| 8. | Frequent Skin Infections or boils? |  |  | 28. Missed | Missed a period in the last 6 months? |  |  |
| 9. | Pneumonia or pleurisy? |  |  | 29. | Do you take birth control? |  |  |
| 10. | Frequent sore throat? |  |  | 30. | Have you ever had a GYN exam? |  |  |
| 11. | Epilepsy (seizure)? |  |  | 31 | GYN Exam in last year? |  |  |
| 12. | Frequent Headaches? |  |  | 32. | History of Heat Illness? |  |  |
| 13. | Migraine Headaches? |  |  | 33. | Hernia? |  |  |
| 14. | Frequent Indigestion? |  |  | 34. | Diabetes? |  |  |
| 15. | Frequent abdominal pain? |  |  | 35. | Thyroid Trouble? |  |  |
| 16. | Stomach or peptic ulcer? |  |  | 36. | Anemia or sickle cell trait? |  |  |
| 17. | Appendicitis? |  |  | 37. | Ear disease, injury or impaired function? |  |  |
| 18. | Colitis or bowel disease? |  |  | 38. | Eye disease. Injury, or impaired function? |  |  |
| 19. | Frequent or bloody diarrhea? |  |  | 39. | Sleep Apnea? |  |  |
| 20. | Hemorrhoids or Rectal Bleeding? |  |  | 40. | Cancer (Tumor)? |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 41. | Depression, nervous break-down, anxiety, seen or been advised to see a psychiatrist? |  |  |
| 42. | Drug or alcohol addiction? |  |  |
| 43. | Any removal or absence of a paired organ (eye, kidney, ovary)? |  |  |
| 44. | Any illness or condition not listed above? |  |  |

List the question number and give details to all YES questions. Use extra sheets as needed.

Please list ALL hospitalizations for medical illnesses. List the dates and reason for the hospitalizations. DATE: REASON:

*Health History Continued*

Have you **EVER** experienced any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| ***SYMPTOMS*** | ***YES*** | ***NO*** | ***EXPLAIN*** |
| Chest pain or tightness with exercise? |  |  |  |
| Palpitations (Skipped Beats)? |  |  |  |
| Had an (ECHO) echocardiogram? |  |  |  |
| Had an (EKG) electrocardiogram? |  |  |  |
| Swollen legs/feet? |  |  |  |
| High or low blood pressure? |  |  |  |
| Heart murmur? |  |  |  |
| Asthma or Exercise induced asthma? |  |  |  |
| Do you use an inhaler? |  |  |  |
| Blood clots? |  |  |  |
| Fainting/Dizzy spells with exercise? |  |  |  |
| Numbness in limbs? |  |  |  |
| Muscle weakness? |  |  |  |
| Impaired memory/confusion? |  |  |  |
| Difficulty concentrating? |  |  |  |
| Panic attacks? |  |  |  |
| Weight loss or gain of 10 or more pounds? |  |  |  |
| Intolerance to exercise? |  |  |  |

Have you **EVER** been diagnosed with:

|  |  |  |  |
| --- | --- | --- | --- |
| **CONDITION** | **YES** | **NO** | **EXPLAIN** |
| Staph infection/ MRSA? |  |  | Has this since resolved? |
| Concussion? |  |  | Date sustained:  Have you received clearance?  Date:  Symptoms: |
| ADD/ADHD? |  |  | Drug and dosage information: |
| Learning Disability? |  |  | Drug and dosage information: |
| Serious Disease/Illness? |  |  | Still receiving treatment? |
| Mental Illness? |  |  | Drug and dosage information: |

In the **LAST YEAR** have you:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Explain** |
| Required Hospitalization? |  |  |  |
| Had an Accident? |  |  |  |
| Required Blood Tests? |  |  |  |
| Required X-Rays, MRI’s, other Imaging? |  |  |  |
| Had an examination by someone other than Central Christian College Team physician? |  |  |  |
| Traveled Outside of the United States? |  |  | Where? |
| Suddenly lost an immediate family member? |  |  | Age? Cause of death? |

*Health History Continued*

|  |  |  |  |
| --- | --- | --- | --- |
| **Personal Information** | **No** | **Yes** | **Quantity/Frequency** |
| Do you wear glasses or contacts? |  |  |  |
| Do you have false teeth or bridge work? |  |  |  |
| Do you smoke cigarettes? If so how many? How often? |  |  |  |
| Do you dip snuff or chew tobacco? If so how much? |  |  |  |
| Do you drink alcoholic beverages? If so how much? |  |  |  |
| Do you take medications or supplements? If so please list. |  |  |  |
| a. |  |  |  |
| b. |  |  |  |
| c. |  |  |  |
| d. |  |  |  |
| e. |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FAMILY HISTORY** | | **Mother** | | **Father** | | **Brother** | | **Brother** | | **Sister** | | **Sister** | |
| If alive list age(s) | |  | |  | |  | |  | |  | |  | |
| If deceased list age at death | |  | |  | |  | |  | |  | |  | |
| Has a history of: | | **NO** | **YES** | **NO** | **NO** | **NO** | **YES** | **NO** | **YES** | **NO** | **YES** | **NO** | **YES** |
| Heart Disease | |  |  |  |  |  |  |  |  |  |  |  |  |
| Stroke | |  |  |  |  |  |  |  |  |  |  |  |  |
| High Blood Pressure | |  |  |  |  |  |  |  |  |  |  |  |  |
| Cancer | |  |  |  |  |  |  |  |  |  |  |  |  |
| Diabetes | |  |  |  |  |  |  |  |  |  |  |  |  |
| Epilepsy | |  |  |  |  |  |  |  |  |  |  |  |  |
| Mental Illness | |  |  |  |  |  |  |  |  |  |  |  |  |
| Blood disease: sickle cell anemia or trait, leukemia etc. | |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Has any family member died of a heart attack under the age of 50? | | | | | | | | | | |  |  |
|  | Has any family member had Marfan syndrome? | | | | | | | | | | |  |  |
|  | Has any family member had hypertrophic cardiomyopathy? | | | | | | | | | | |  |  |
|  | Have you or any family member been diagnosed with Long QT syndrome? | | | | | | | | | | |  |  |

*Health History Continued*

|  |  |  |  |
| --- | --- | --- | --- |
| **ALLERGIES** | **No** | **Yes** | **If YES describe the reaction you had** |
| Penicillin |  |  |  |
| Sulfa medications |  |  |  |
| Tetracycline medications |  |  |  |
| Codeine |  |  |  |
| Bees or Stinging Insects |  |  |  |
| Anti-inflammatory medications |  |  |  |
| Tetanus Antitoxin or Serums |  |  |  |
| Others (list medications and foods) | | | Describe Reaction: |
| a. | | |  |
| b. | | |  |
| c. | | |  |
| d. | | |  |
| e. | | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **PRIOR IMMUNIZATIONS** | **NO** | **YES** | **Approximate date of last shot** |
| Tetanus, Diphtheria, and Pertussis |  |  |  |
| Measles |  |  |  |
| Chickenpox |  |  |  |
| Meningitis |  |  |  |
| Measles-Mumps-Rubella |  |  |  |

Please give name address, and phone number of your primary care provider or family doctor. Please list your most recent Certified Athletic Trainer or Physical Therapist

Doctor Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AT/PT Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_